

Nursing Progress Note (Long Version)

This form is to be completed by a LPN, RN, BSN, or MSN when providing nursing services primarily in residential or inpatient substance use treatment programs, such as TSS, Detox, etc. Nurses with a RNCS or an APRN with prescribing privileges should complete the Psychopharmacology Progress Note.

There are two different versions of the Nursing Progress Note – a short and long version. The short version is to provide adequate documentation for short length services such as injections, etc. while the long version has additional data fields that support the focus of the Psychopharmacology Progress Note including an interim history and mini mental status section.

Data Field	Identifying Information Instructions
Person's Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Person's DOB	Record the person's date of birth.
Organization Name	Record the organization for whom you are delivering the service.
List of Names of Persons Present	Check appropriate box: <i>Person Present</i> ; <i>Person No Show</i> ; <i>Person Cancelled</i> . If <i>Provider Cancelled</i> is checked, document explanation as relevant. If <i>Others Present</i> is checked, identify name(s) and relationship(s) to person.
Interim History	Record a review of the person's condition, medications, dosages, any allergic reactions, and health changes since last encounter, person's assessment of progress related to symptoms, side effects, overall functioning, effectiveness of medications and medication compliance. If no changes are reported or observed, indicate whether person is at baseline, no progress made, meds still working, etc.
Person's Condition: Mood/affect Thought Process/Orientation Behavior Functioning Medical Condition Substance Use	This is a mini-mental status exam. Check appropriate box to indicate person's condition or to indicate <i>No Change</i>. Also, describe any changes. Note: Notable is defined as behavior or symptoms different from the person's baseline status. These changes may be signs the person is experiencing increased problems or distress or may indicate an improvement in functioning/symptoms/behavior. Example: Thought process/orientation is marked <i>Notable</i> and the comments are: "John is distracted and responding to voices he is hearing today." However, if John's baseline is that he always hears some voices and responds, a <i>Notable</i> comment would not be needed unless the intensity or impact of the voices on John is significantly different than his baseline.
New Issue(s) Presented Today	There are four options available for staff using this section of the progress note: 1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals. 2. If person reports a new issue that was resolved during the session check the "New Issue resolved, no CA Update required" box. Briefly document the new issue, identify the interventions used in the Therapeutic Interventions Section and

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**United States. Congress. House.
Committee on Ways and Means**

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The OTA's Guide to Writing SOAP Notes Sherry Borcharding, Marie J. Morreale, 2007 Written specifically for occupational therapy assistants The OTA's Guide to Writing SOAP Notes Second Edition is updated to include new features and information This valuable text contains the step by step instruction needed to learn the documentation required for reimbursement in occupational therapy With the current changes in healthcare proper documentation of client care is essential to meeting legal and ethical standards for reimbursement of services Written in an easy to read format this new edition by Sherry Borcharding and Marie J Morreale will continue to aid occupational therapy assistants in learning to write SOAP notes that will be reimbursable under Medicare Part B and managed care for different areas of clinical practice New Features in the Second Edition Incorporated throughout the text is the Occupational Therapy Practice Framework along with updated AOTA documents More examples of pediatrics hand therapy and mental health Updated and additional worksheets Review of grammar documentation mistakes Worksheets for deciphering physician orders as well as expanded worksheets for medical abbreviations Updated information on billing codes HIPAA management of health information medical records and electronic documentation Expanded information on the OT process for the OTA to fully understand documentation and the OTA's role in all stages of treatment including referral evaluation intervention plan and discharge Documentation of physical agent modalities With reorganized and shorter chapters The OTA's Guide to Writing SOAP Notes Second Edition is the essential text to providing instruction in writing SOAP notes specifically aimed at the OTA practitioner and student This exceptional edition offers both the necessary instruction and multiple opportunities to practice as skills are built on each other in a logical manner Templates are provided for beginning students to use in formatting SOAP notes and the task of documentation is broken down into small units to make learning easier A detachable summary sheet is included that can be pulled out and carried to clinical sites as a reminder of the necessary contents for a SOAP note Updated information expanded discussions and reorganized learning tools make The OTA's Guide to Writing SOAP Notes Second Edition a must have for all occupational therapy assistant students This text is the essential resource needed to master professional documentation skills in today's healthcare environment Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), 1986 **Charting Made Incredibly Easy!** Springhouse, 2002 Part of the Springhouse Incredibly Easy Series™ this Second Edition provides current information about charting in a comprehensible clear fun and concise manner Three sections cover Charting Basics Charting in Contemporary Health Care and Special Topics New features include expanded coverage of computerized documentation and charting specific patient care procedures plus current JCAHO standards both in the text and appendix chapter summaries and a new section with case study questions and answers Amusing graphics and cartoon characters call special attention to important information Entertaining logos throughout the text alert the reader to critical information Thought Pillows identify key features of documentation forms and the glossary defines difficult or often

misunderstood terms Home Care Nursing Handbook Carolyn J. Humphrey, 1998 Here s the brand new third edition of the very popular Home Care Nursing Handbook considered by readers as a beacon of excellence in home care nursing Now better than ever this book that so many nurses have turned to for immediate excellent advice has been significantly expanded It is reorganized for quicker access to expert guidance devotes separate chapters to interventions for each impairment Use this guide every day to assess situations quickly develop efficient plans of care provide accurate intervention strategies document patient care quickly precisely promote quality patient outcomes in the shortest number of contacts so much more This book is a vital addition to critical pathways point of care computer systems OASIS data collection **Geriatric**

Medicine Christine K. Cassel, Rosanne Leipzig, Harvey Jay Cohen, Eric B. Larson, Diane E. Meier, 2006-05-29 Since the publication of the third edition of Geriatric Medicine extraordinary advances have occurred in the science of aging and the potential for biomedical research to give us answers to many if not most of the age related disorders that threaten the quality of life in older years At the most basic level the successful mapping of the human genome was declared complete in the fall of 2000 Understanding the map of the human genome is as important as understanding the map of genomes of important laboratory species ranging from the microscopic worms and fruit flies used in most classic genetic studies to rodents such as laboratory mice and eventually to primates on which much of the research on the aging human brain is done The genetic maps of all of these species including our own does not answer clinical questions but it does open the door to dramatic rapid and efficient answers to questions about the genetic polymorphisms related to diseases in humans The telomerase story also unfolded since the third edition Telomerase is an enzyme responsible for maintaining the telomeres the redundant DNA portions at the end of chromosomes whose shortening seems to be linked directly to cell senescence apoptosis and the control over cell death which at the level of the individual cell seems to be linked to the decline of organ function and eventually aging and death within the organism **Documentation for Physical Therapist Practice** Jacqueline A. Osborne, 2015-07-31

Documentation for Physical Therapist Practice A Clinical Decision Making Approach provides the framework for successful documentation It is synchronous with Medicare standards as well as the American Physical Therapy Association s recommendations for defensible documentation It identifies documentation basics which can be readily applied to a broad spectrum of documentation formats including paper based and electronic systems This key resource utilizes a practical clinical decision making approach and applies this framework to all aspects of documentation This text emphasizes how the common and standard language of the Guide to Physical Therapist Practice and the International Classification of Functioning Disability and Health ICF model can be integrated with a physical therapist s clinical reasoning process and a physical therapist assistant s skill set to produce successful documentation Includes content on documentation formations Initial Evaluations Re examination Notes Daily Notes Conclusion of the Episode of Care Summaries Home Exercise Program Reviews all the important issues related to style types of documentation and utilization of documentation Covers

documentation relevant in different settings inpatient home health skilled nursing facility outpatient Helps students learn how to report findings and demonstrate an appropriate interpretation of results Includes up to date information in line with APTA Guidelines for Defensible Documentation World Health Organization International Classification of Functioning Disability and Health Mode and Medicare Reviews electronic documentation ICD 9 ICD 10 and CPT codes Includes important chapters on Interprofessional Communication Legal Aspects Principles of Measurement *Selected Issues in Medicare Program Policy* United States. Congress. House. Committee on Ways and Means. Subcommittee on Health,1975 *Pain Management* Richard S. Weiner,2001-12-20 This authoritative reference the Sixth Edition of an internationally acclaimed bestseller offers the most up to date information available on multidisciplinary pain diagnosis treatment and management *Pain Management A Practical Guide for Clinicians* is a compilation of literature written by members of The American Academy of Pain Management the largest multidisciplinary society of pain management professionals in North America and the largest physician based pain society in the United States This unique reference covers both traditional and alternative approaches and discusses the pain of children as well as adult and geriatric patients It includes approximately 60 new chapters and each chapter is written to allow the reader to read independently topics of interest and thus may be viewed as a self contained study module The collection of chapters allows an authoritative self study on many of the pressing issues faced by pain practitioners Regardless of your specialty or medical training or whether you are in a large hospital or a small clinic if you work with patients in need of pain management this complete reference is for you *The President's 1978 Tax Reduction and Reform Proposals* United States. Congress. House. Committee on Ways and Means,1978 *Professional Standards Review Organizations* United States. Congress. House. Committee on Ways and Means. Subcommittee on Oversight,1977 **Nursing Home Ombudsman Services for the Elderly** Community Research Applications, Inc,1977 *Conditions and Problems in the Nation's Nursing Homes* United States. Congress. Senate. Special Committee on Aging. Subcommittee on Long-Term Care,1965 Handbook of Home Health Care Administration Marilyn D. Harris,1997 Table of Contents Foreword Introduction Ch 1 Home health administration an overview 3 Ch 2 The home health agency 16 Ch 3 Medicare conditions of participation 27 Ch 4 The joint commission s home care accreditation program 63 Ch 5 CHAP accreditation standards of excellence for home care and community health organizations 71 Ch 6 Accreditation for home care aide and private duty services 81 Ch 7 ACHC accreditation for home care and alternate site health care services 86 Ch 8 Certificate of need and licensure 92 Ch 9 Credentialing organizational and personnel options for home care 101 Ch 10 The relationship of the home health agency to the state trade association 111 Ch 11 The national association for home care and hospice 115 Ch 12 The visiting nurse association of America 124 Ch 13 Self care systems in home health care nursing 131 Ch 14 Home health care documentation and record keeping 135 App 14 A COP standards pertaining to HHA clinical record policy 147 App 14 B Abington Memorial Hospital home care clinical records 150 Ch 15 Computerized clinical documentation

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Development Handbook for State and Local Agencies on Nursing Home Ombudsman Services for the Elderly Community Research Applications, Inc,1978 **Conditions and Problems in the Nation's Nursing Homes: New York City, N.Y., August 2 and 3, 1965** United States. Congress. Senate. Special Committee on Aging. Subcommittee on Long-Term Care,1965 *Fundamentals of Nursing: Concepts and Competencies for Practice* Ruth F. Craven,Constance Hirnle,Christine Henshaw,2019-12-26 Providing a big picture approach to nursing practice Fundamentals of Nursing Concepts and Competencies for Practice 9th Edition instills the foundational knowledge and clinical skills to help your students think critically and achieve positive outcomes throughout the nursing curriculum and in today s fast paced clinical settings This revision immerses students in a proven nursing framework that clarifies key capabilities from promoting health to differentiating between normal function and dysfunction to the use of scientific rationales and the approved nursing process and includes new Unfolding Patient Stories and Critical Thinking Using QSEN Competencies NCLEX style review questions online and within the book further equip students for the challenges ahead **Craven & Hirnle's Fundamentals of Nursing** Christine Henshaw,Renee Rassilyer,2023-12-15 Instilling a foundation for success from the classroom to the clinical setting Craven Hirnle s Fundamentals of Nursing Concepts and Competencies for Practice 10th Edition fosters the strong critical thinking clinical judgment clear communication and sound clinical skills students need to succeed throughout the nursing curriculum and to meet the challenges practicing nurses confront each day Drawing on the latest clinical evidence this immersive text trains students to think and act like nurses immersing them in a proven nursing process framework that clarifies key capabilities from promoting health to identifying dysfunction to the use of scientific rationales and the nursing process *Program Development Handbook for State and Area Agencies on Nursing Home Ombudsman Services for the Elderly* Community Research Applications, Inc,1978 Prepared for the Administration on Aging

Documentation Basics Mia Erickson,Mia L. Erickson,2012 Complete and accurate documentation is one of the most important skills for a physical therapist assistant to develop and use effectively The new Second Edition of Documentation Basics A Guide for the Physical Therapist Assistant continues the path of teaching the student and clinician documentation from A to Z Mia Erickson and Rebecca McKnight have updated this Second Edition to reflect changes of the American Physical Therapy Association and the ever evolving profession Updated inside Documentation Basics A Guide for the Physical Therapist Assistant Second Edition The discussion on integrating disablement into documentation The discussion on how a PTA can show medical necessity and need for skilled care The discussion on using documentation to communicate with other providers Writing the assessment and plan to coincide with the initial documentation Sample notes completed on forms More examples and practice including physical agents school based services paediatrics traumatic brain injury spinal cord injury and interventions consistent with the Guide to Physical Therapist Practice Medicare reimbursement in different settings The importance of consistent reliable and valid measurements How to improve communication and consistency between

documentation by the PT the PTA The discussion on disablement has also been updated shifting away from the Nagi Model toward the International Classification of Functioning Disability and Health ICF In addition the PTA Normative Model has been integrated throughout to include more information on clinical decision making New inside Documentation Basics A Guide for the Physical Therapist Assistant Second Edition Navigating the PT plan of care A step by step model for PTAs to use as they navigate the initial PT documentation and plan of care How the PTA uses the PT goals from the initial examination and evaluation Positive and negative aspects of using electronic documentation and a discussion on integrating SOAP notes and the problem oriented medical record into electronic documentation Sample notes and discussion of documentation in school based settings early intervention skilled nursing settings in patient rehabilitation and direct access Medicare Parts C and D Cash based services and pro bono services Instructors in educational settings can visit www.efacultylounge.com for additional material to be used for teaching in the classroom Documentation Basics A Guide for the Physical Therapist Assistant Second Edition is the perfect guide for all physical therapist assistant students and clinicians who want to update and refine their knowledge and skills in documentation

Nursing Documentation Made Incredibly Easy Kate Stout, 2018-06-05 Publisher's Note Products purchased from 3rd Party sellers are not guaranteed by the Publisher for quality authenticity or access to any online entitlements included with the product Feeling unsure about the ins and outs of charting Grasp the essential basics with the irreplaceable Nursing Documentation Made Incredibly Easy 5th Edition Packed with colorful images and clear as day guidance this friendly reference guides you through meeting documentation requirements working with electronic medical records systems complying with legal requirements following care planning guidelines and more Whether you are a nursing student or a new or experienced nurse this on the spot study and clinical guide is your ticket to ensuring your charting is timely accurate and watertight Let the experts walk you through up to date best practices for nursing documentation with NEW and updated fully illustrated content in quick read bulleted format NEW discussion of the necessary documentation process outside of charting informed consent advanced directives medication reconciliation Easy to retain guidance on using the electronic medical records electronic health records EMR EHR documentation systems and required charting and documentation practices Easy to read easy to remember content that provides helpful charting examples demonstrating what to document in different patient situations while addressing the different styles of charting Outlines the Do's and Don'ts of charting a common sense approach that addresses a wide range of topics including Documentation and the nursing process assessment nursing diagnosis planning care outcomes implementation evaluation Documenting the patient's health history and physical examination The Joint Commission standards for assessment Patient rights and safety Care plan guidelines Enhancing documentation Avoiding legal problems Documenting procedures Documentation practices in a variety of settings acute care home healthcare and long term care Documenting special situations release of patient information after death nonreleasable information searching for

contraband documenting inappropriate behavior Special features include Just the facts a quick summary of each chapter s content Advice from the experts seasoned input on vital charting skills such as interviewing the patient writing outcome standards creating top notch care plans Nurse Joy and Jake expert insights on the nursing process and problem solving That s a wrap a review of the topics covered in that chapter About the Clinical Editor Kate Stout RN MSN is a Post Anesthesia Care Staff Nurse at Doshier Memorial Hospital in Southport North Carolina

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